moving to the optimum situation in which these individuals and their support system can address their needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "D2"

Case management for Target Group "D2" means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group "D2" requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services which documents each case management function provided.

A. Intake and screening. This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.

B. Assessment and reassessment. During this phase the case management team must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

C. Case management plan and coordination. The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;

2. the continuity of service;

3. the avoidance of duplication of service (including case management services); and,

4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.

D. Implementation of the case management plan. Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

E. Crisis intervention. Crisis intervention by a case management team includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. Monitoring and follow-up. As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient's satisfaction with the services provided and advising the preparer of the case

management plan whether the recipient is satisfied; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. Counseling and exit planning. This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments. The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

   An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

   An assessment must be completed by a case management team within 30 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as in integral part of the case management plan.

   An assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. Case management plan. A written case management plan must be completed by the

case management team for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under CASE MANAGEMENT FUNCTIONS.

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment and must be address those needs necessary to achieve and maintain stabilization.

The case management plan must be reviewed and updated by the case management team as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

a. those activities which the recipient is expected to undertake within a given period of time for purposes of accomplishing each case management goal;

b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;

c. the type of treatment program or service providers to which the recipient will be referred;

d. the activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and the method by which such services shall be provided;

e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed; and

f. whether the program plans to place a client into transitional status during the next six month period covered by the plan.

3. Continuity of service. Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is

no longer required by the recipient; the recipient moves from the social services district; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services.

Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Office of Mental Health.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;

3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Waiver except as addressed in the July 25, 2000 HCFA letter to State Medicaid Directors which informed the States that Targeted case management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community.

While the activities of case management services secure access to an individual's needed service for the client, the activities of case management do not include:

1. the actual provision of the service;

2. Medicaid eligibility determinations/redeterminations;

3. Medicaid preadmission screening;

4. prior authorization for Medicaid services;

5. required Medicaid utilization review;

6. EPSDT administration;

7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;

8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and

9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

LIMITATIONS SPECIFIC TO TARGET GROUP "D2"

In order to support an intensive, personal and proactive service, Blended and Flexible Case Managers will carry case loads based on their designation as Intensive Case Managers or Supportive Case Managers. Intensive Case Managers are responsible to provide a minimum of 48 total monthly face to face contacts per manager. Supportive Case Managers are required to provide in the aggregate a minimum of twice the number of visits as the number of Supportive Case management clients. For children's programs, a maximum of 25% of the total aggregate visits can be face-to-face contacts with collaterals as defined in 14 NYCRR Part 587.

Individuals may be referred to case management by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Blended and Flexible Case Management Program will determine which clients are appropriate for case management services and at what level (i.e., that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)

Clients who appear ready for disenrollment from the program can be placed into transitional status for a period not to exceed two months. During that time period the program can bill for the client as long as at least one face-to-face contact per month is provided. Clients who are disenrolled may be placed back into active status expeditiously when the need arises.

E. QUALIFICATIONS OF PROVIDERS

1. Providers

New York State Office of Mental Health (OMH) will authorize as Case Management providers either OMH employees meeting the qualifications approved below or employees of those organizations determined by OMH and certified to the DOH to have the capacity to provide specialized Case Management Services and having written agreements with appropriate mental health providers and other human service providers so that DOH can enroll the providers in the Medicaid program. Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services that are approved by OMH. Providers may include:

a. facilities licensed or certified under New York State law or regulation;

b. health care or social work professionals licensed or certified in accordance with New York State law;

c. state and local governmental agencies; and

d. home health agencies certified under New York State law.

2. Case Managers

Intensive Case Managers: The Intensive Case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

a. one year of case management experience and a degree in a health or human services field; or

b. one year of case management experience and an additional year of experience in other activities with the target population; or

c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development or case management plans; or

d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

Supportive Case Managers: Must have two years in providing direct services or in a substantial number of activities outlined under "Case Management Functions" to people who are mentally disabled, or homeless. The following may be substituted for this requirement:

a. One year of case management experience and an associate degree in a health or human services field: or

b. One year of case management experience and an additional year of experience in other activities with the target population; or

c. A bachelor's or master's degree which includes a practicum encompassing a substantial number of activities with the target population; or

d. The individual meets the regulatory requirements for case manager of a State Department within New York State.

Minimum Qualifications for Appointment As A Coordinator of Blended and Flexible Case Management Services

A master's degree in a human services field* and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing

and financial services). Two years of this experience must have involved supervisory or managerial experience for a mental health program or major mental health program component.

* For purposes of qualifying for these titles a "Human Services Field" includes Social Work, Psychology, Nursing, Rehabilitation, Education, Occupational Therapy, Physical Therapy, Recreation or Recreation Therapy, Counseling, Community Mental Health, Child and Family Studies, Speech and Hearing, Sociology.

While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;

2. Medicaid eligibility determinations/redeterminations;

3. Medicaid preadmission screening;

4. prior authorization for Medicaid services;

5. required Medicaid utilization review;

6. EPSDT administration;

7. activities in connection with "lock in" provisions under 1915 (a) of the Social Security Act;

8. institutional discharge planning required of hospitals, SNFS, ICFs and ICF/MRs;

9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan; and

10. representative payee services.

LIMITATIONS SPECIFIC TO TARGET GROUP "H"

In order to support a personal and proactive service, Supportive Case Managers will carry an average active case load of between 20-30 clients. Supportive Case Managers will see active clients a minimum of two times during a month. SCM employs a team approach to the provision of case management service. The inclusion of the SCM program in the service target group H will assure that the nature and intensity of services vary with individuals changing needs. These individuals may be referred to the SCM by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact.

D. QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP "H"

1. Providers

The New York State Office of Mental Health (OMH) will authorize as Case Management providers either employees of OMH meeting the qualifications described below or employees of those organizations determined by OMH and certified to the Department of Health (DOH) to have the capacity to provide specialized Case Management Services and

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having written agreements with appropriate mental health providers and other human service providers so that DOH can enroll the providers in the Medicaid program.

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TYPE OF SERVICE

Case Management Services
Target Group D2:

Medicaid eligible individuals who:

(I) are seriously and persistently mentally ill, and

(ii) require intensive, personal and proactive intervention to help them obtain service, which will permit or enhance functioning in the community, and

(iii) either have symptomatology which is difficult to treat in the existing mental health care system; or are unwilling or unable to adapt to the existing mental health care system; or need support to maintain their treatment connections and/or residential settings.

METHOD OF REIMBURSEMENT

Each Flexible and Blended Case Management program will receive a regional rate approved by the Division of the Budget determined by its staffing combination (i.e., the number of Intensive Case Managers and Supportive Case Managers on a particular team). No bill can be generated for a particular client unless that client has received at least two face-to-face contacts during the month. However, in order to bill the program as a whole must provide in the aggregate four visits times the number of Medicaid recipients per month per Intensive Case Management staff and two times the number of Medicaid recipients per month per Supportive Case Manager. For seriously emotionally disturbed children's programs or providers, up to 25% of the total required aggregate Intensive Case Management visits may be made to collaterals as defined in 14 NYCRR Part 587. Clients who appear to be ready for disenrollment from the program can be placed into transitional status. The program can bill for the individual in transitional status during that period if the client receives a minimum of one visit, but in no instance may a client remain in transitional status for more than two months.

TYPE OF SERVICE

Case Management Services
Target Group D1:

Medicaid eligible individuals who are served by the New York State Office of Mental Health's Intensive Case Management Program and who:

(I) are seriously and persistently mentally ill and

(ii) require intensive, personal and proactive intervention to help them obtain service, which will permit or enhance functioning in the community and

(iii) either have symptomatology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

METHOD OF REIMBURSEMENT

For payments to Flexible Intensive Case Management providers in New York State a monthly fee shall be established for each provider and approved by the Division of the Budget. Providers may bill for the monthly rate only if the Medicaid eligible adult ICM client has been seen by the case manager a minimum of two times during the month. Clients who appear to be ready for disenrollment from the program can be deemed to be in transitional status, and the program can bill during that period if the client receives a minimum of one visit, but in no instance may a client remain in transitional status for more than two months.

The program as a whole must provide in the aggregate four visits times the number of Medicaid recipients per month per case manager. For seriously and emotionally disturbed children's programs/providers, up to 25% of the total required aggregate visits may be made to collaterals as defined in 14 NYCRR Part 587.

TYPE OF SERVICE

Case Management Services
Target Group H:

The target group consists of medical assistance eligibles who are served by the Office of Mental Health's Supportive Case Management Program and who:

(i) are seriously mentally ill; and

(ii) require personal and proactive intervention to help them obtain and maintain services, which will permit or enhance functioning in the community; and,

(iii) either have symptomology which is difficult to treat in the existing mental health care system or need support to maintain their treatment connections and/or residential settings.

These individuals include:

(1) heavy service users who are known to staff in emergency rooms, acute inpatient units, and psychiatric centers as well as to providers of other acute and crisis services, who may have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities; or

(2) persons with recent hospitalizations in either state psychiatric centers or acute care general hospitals; or,

METHOD OF REIMBURSEMENT

Provider Reimbursement for Target Group H

For payment to Supportive Case Management providers in New York State, monthly fees shall be established for each region for SCM Medicaid programs which are not OMH operated and Statewide fees for SCM Medicaid programs operated by OMH. Providers may bill for the monthly fee only if the medicaid eligible recipient has been seen by the case manager a minimum of two times during the month. Clients ready for disenrollment may be placed into "transitional" status for a period not to exceed two months, and during that period the program/provider can bill for a maximum face to face contact of one visit per month. The minimum amount of time required for a client encounter to be credited for the purpose of Medicaid reimbursement is 15 minutes.

The fees for SCM providers will be recommended by OMH, and approved by the State Division of the Budget (DOB). OMH will consult with DOH and DOB regarding any changes to the regulations.

1. The regional fees for SCM Medicaid providers which are not OMH operated shall be based upon OMH approved expenditures per SCM in each OMH region and the maximum caseload per SCM approved by OMH for the individual provider. These regional fees shall be developed as follows:

(3) mentally ill who are homeless and live on the streets or in shelters; or,

(4) seriously emotionally disturbed children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and who may, without intervention, be institutionalized, incarcerated or hospitalized; or,

(5) people in need of ongoing mental health support in order to maintain or enhance community tenure.

The aim is to benefit these recipients by reducing hospitalization and reliance on emergency psychiatric services, as well as increasing employment, encouraging better medication management and generally improving the individual's quality of life within the community.

METHOD OF REIMBURSEMENT, con.

a) Each SCM provider shall be approved for maximum monthly caseloads per SCM employed by the provider of either 20 or 30 enrolled clients.

b) The regional monthly fee for SCM providers approved for 20 clients shall be the OMH approved expected expenditures per SCM in the region divided by the product of 20 x 12 months x 90%.

c) The regional monthly fee for SCM providers approved for 30 clients shall be the OMH approved expected expenditures per SCM in the region divided by the product of 30 x 12 months x 90%.

2. The State monthly fees for SCMs employed directly by OMH in either free standing or shared staff arrangements with caseloads of 20 clients or 30 clients shall be the lesser of fees established using the methodology described in 1, above, or fees prescribed by DOB.